PINNACLE
Orthopedic & Spine Specialists

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Motor Vehicle Accident Questionnaire

NAME:_____ TODAY'S DATE:_____

Date of Accident:_____ Time of Accident:_____

Place of Accident:_____

Diagram of Accident: (please draw a diagram of the accident)

Details:

Number of Occupants in Car____

1. Were you the: □ driver □ passenger: □ front seat
   □ back seat- driver's side
   □ back seat- passenger's side
2. Were you wearing a seat belt? □ yes □ no
   □ lap belt
   □ lap & shoulder belt
   □ head rest
   □ air bag
3. What kind of car were you in: Model_____Year_____
4. Other vehicles involved:_____
5. List your injuries:_____
6. Loss of Consciousness? □ yes □ no
7. Others injured in your car:_____
8. What is your occupation:_____
9. Did you lose time from work?: □ yes □ no dates off:_____
10. Did you return to full duties? □ yes □ no when:_____ part-time when: _____
11. Did you receive medical treatment at the scene of the accident? □ yes □ no
12. Where did you receive medical treatment?_____

Cameron B. Huckell, M.D.
Adult & Pediatric Spinal Surgery

Graham R. Huckell, M.D.
Joint Replacement & Arthroscopy General Orthopedics

A. Marc Tetro, M.D.
Hand, Shoulder & Elbow Surgery, Arthroscopy & Microsurgery

Kathleen Miller, CPA, MBA
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13. When did you receive medical treatment?_____
14. What were you told your injuries were?_____
15. Did you have x-rays taken? □ yes □ no
    where:_____when:_____
16. What treatment was prescribed?_____
17. Were you place on any medication?
    Type:_____How long:_____
18. Are you on medication now?
    Type:_____How long:_____
19. Did you have surgery? □ yes □ no
    When:_____Type:_____
20. Have you had any of the following? □ Physical Therapy
    □ Chiropractic Treatments
    □ Other:_____
21. Are you experiencing any residual discomfort? □ yes □ no
    If yes, please describe:_____
22. Have you seen any doctors for this problem? □ yes □ no
    When:_____Doctor:_____Treatment prescribed:_____
23. Is there anything you are <u>unable</u> to do that you did prior to your accident?_____
24. Is there anything you have <u>difficulty</u> doing?
    _____
25. Present disability?_____

26. Did you have pain immediately following the accident? Indicate areas:

27. Indicate you pain the next day (if different):

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